

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6018

CERTIFICATE OF DEATH

86001

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St Michaels</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St Michaels</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Andrew</u> First <u>J</u> Middle <u>Barnett</u> Last		4. DATE OF DEATH Month <u>5</u> Day <u>12</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/1/175</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Oyster</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Barnett</u>		14. MOTHER'S MAIDEN NAME <u>MARIA Turner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-018229</u>	
17. INFORMANT <u>Hester Dummer</u> Address <u>St. Michaels Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Congestive Heart Fail</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Dis.</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary Fibillation</u>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/1/59</u> , 19 <u>59</u> , to <u>12/12/59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11/12/59</u> , 19 <u>59</u> , and that death occurred at <u>6:00 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. Paul Whith</u> M.D.		ADDRESS (Street, city or town, state) <u>Box 487, St. Michaels, Md</u> DATE SIGNED <u>5-13-59</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/18/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Michaels Cem</u>		22d. LOCATION (City, town, or county) (State) <u>St Michaels Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Dashiell</u> ADDRESS <u>Easton, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 19 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

6019

10001

DATE OF DEATH

PLACE OF DEATH

HOSPITAL

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be obtained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G242 5-19-59 et

CERTIFICATE OF DEATH

Reg. Dist. No.

06002

6004

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 EASTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hosp.</u>		d. STREET ADDRESS <u>Glebe Road</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Dennis</u> Middle <u></u> Last <u>BRICE</u>		4. DATE OF DEATH Month <u>5</u> Day <u>1</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 1899</u>
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Term laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Curle Brice</u>		14. MOTHER'S MAIDEN NAME <u>Maggie Sampson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Mrs. Maggie Sampson Easton, Md.</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio megal</u> DUE TO (c) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>19</u> to <u>19</u> , that I last saw the deceased alive on <u>7 15</u> and that death occurred at <u>7 15</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>219 S. Washington St. U. Md.</u> DATE SIGNED <u>May 19 59</u>			
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u> M.D.		PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u> <u>Easton, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/14/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>New Chapel Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Easton Rt. 3. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Dashed</u> ADDRESS <u>Easton Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 11 59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Fraw</u>			

100

6003 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FEDERALSBURG</u> <u>Oak Beach</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MEMORIAL</u>		d. STREET ADDRESS <u>69 X-3</u> <u>OAK BEACH, NEW YORK</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE W. B. BURR</u>		4. DATE OF DEATH Month Day Year <u>MAY 21 1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUGUST 10, 1892</u>
9. AGE (In years last birthday) yrs. <u>66</u>		10. IF UNDER 1 YEAR Months Days Hours Min. <u>1 Mo</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BUILDER AND CONTRACTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NEW YORK</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE W. BURR</u>		14. MOTHER'S MAIDEN NAME <u>MARY DELIA DURYEA</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WWI</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>WILMURT B. LINKER, NEW YORK, N.Y.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of liver & spleen peritoneum</u> 153.8 DUE TO <u>liver</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of large bowel</u> DUE TO (c) <u>liver</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 Mo</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>30 Apr 59</u> , 19 <u>59</u> , to <u>21 May 59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>20 May 59</u> , 19 <u>59</u> , and that death occurred at <u>5:25 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas Harrison</u> M.D.		ADDRESS (Street, city or town, state) <u>Easton, Maryland</u> DATE SIGNED <u>21 May 59</u>	
PHYSICIAN'S NAME (Type) <u>THORSTON HARRISON</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>MAY 23 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HILL CREST CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>FEDERALSBURG, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Thompson Son, Federalburg md</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 26 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retained far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10003

6007 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13

DATE OF DEATH		PLACE OF DEATH	
1941		BALTIMORE	
DECEASED'S NAME		SEX	
JOHN		M	
AGE		RACE	
45		W	
MARRIED		OCCUPATION	
Y		LABORER	
CAUSE OF DEATH		MANNER OF DEATH	
HEART DISEASE		NATURAL	
DETAILS OF CAUSE OF DEATH		DATE OF BURIAL	
CORONARY THROMBOSIS		1941	
PLACE OF BURIAL		CITY	
BALTIMORE		MD	
NAME OF FUNERAL HOME		NAME OF MINISTER	
JOHN		JOHN	
ADDRESS		ADDRESS	
BALTIMORE		BALTIMORE	
STATE		STATE	
MD		MD	
CITY		CITY	
BALTIMORE		BALTIMORE	
COUNTY		COUNTY	
BALTIMORE		BALTIMORE	
SIGNATURE OF REGISTRAR		SIGNATURE OF MINISTER	
JOHN		JOHN	
DATE OF REGISTRATION		DATE OF REGISTRATION	
1941		1941	

1

THIS IS TO CERTIFY THAT THE ABOVE IS A TRUE AND CORRECT COPY OF THE ORIGINAL RECORD AS KEPT IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND.

FOR STATE
HEALTH DEPT.

6006

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06004

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Talbot</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Mem Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Alice</u> First <u>BESSIE</u> Middle <u>Cahall</u> Last		4. DATE OF DEATH <u>May</u> Month <u>4</u> Day <u>1959</u> Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-16-10</u>
9. AGE (In years last birthday) <u>49</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WORK</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>Rosa V. Hartsock</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-18-4808</u>	
17. INFORMANT <u>Hosp. records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>gave rise to immediate cause</u> (a), stating the underlying cause last. DUE TO (c) <u>gave rise to immediate cause</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> o. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Louis Welch</u>		DATE SIGNED <u>5-4-59</u>	
EXAMINER'S NAME (Type) <u>WELTY</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 7, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greensboro Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Greensboro, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.J. Frampton and Son, Federalburg, Maryland</u>		24a. REC'D BY REGISTRAR <u>MAY 7 '59</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

6019

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06005

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY TALBOT b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NR TILGHMAN c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CALVERT c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SUNDERLAND d. STREET ADDRESS 04X-2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LEROY First CONTEE Middle CONTEE Last 4. DATE OF DEATH Month MAY Day 31 Year 1959				5. SEX MALE 6. COLOR OR RACE COL 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH MAY 1916 9. AGE (In years last birthday) 43 yrs. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME WILLIAM CONTEE			
14. MOTHER'S MAIDEN NAME IDA JACKSON				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT WM CONTEE Address SUNDERLAND Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACCIDENTAL DROWNING 850.X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) BODY RECOVERED OFF TILGHMAN JUNE 5, 1959 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) FELL OFF CABIN CRUISER IN CHESAPEAKE BAY							
20c. TIME OF INJURY Hour a. m. p. m. 5-31 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) CHES. BAY		20f. (City or town) (County) (State) Sharps Is. Talbot	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Louis Welty EXAMINER'S NAME (Type) WELTY				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED 6-5-59							
22a. BURIAL, CREMATION, REMOVAL (Specify) June 6, 59		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY St. Edmund		22d. LOCATION (City, town, or county) (State) Sunderland Md	
23. FUNERAL DIRECTOR'S SIGNATURE P.E. Sewell ADDRESS Brown Road				24a. REC'D BY REGISTRAR DATE JUN 9 '59		24b. REGISTRAR'S SIGNATURE Christ E. Hunt	

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FOR STATE
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2018

NAME OF DECEASED JAMES H. HARRIS		AGE 45		SEX M		RACE W	
DATE OF DEATH JAN 15 1918		PLACE OF DEATH HOME		CITY BALTIMORE		COUNTY BALTIMORE	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		OCCUPATION CLOCKMAKER		EDUCATION HIGH SCHOOL	
PREVIOUS ILLNESS NONE		TREATMENT NONE		HISTORY NONE		FAMILY HISTORY NONE	
SIGNATURE OF EXAMINER J. H. HARRIS		DATE JAN 15 1918		PLACE BALTIMORE		COUNTY BALTIMORE	

6007 CERTIFICATE OF DEATH

Reg. Dist. No. 06006

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>15 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hosp</u>				d. STREET ADDRESS <u>101 S. Main St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Allison</u> Middle <u>R.</u> Last <u>Covey</u>				4. DATE OF DEATH Month <u>May</u> Day <u>1</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 2, 1931</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min. <u>0</u>		IF UNDER 24 HRS. Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance Executive</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Anderson, T. Covey</u>				14. MOTHER'S MAIDEN NAME <u>Sally Hubbard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>yes</u>		17. INFORMANT <u>Harvey Williams - Federalburg, Md.</u> Address <u>Federalburg, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 610X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic pyelonephritis</u> DUE TO (c) <u>Obstructive uropathy - prostatic hypertrophy</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>unknown</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Masch</u> , 19 <u>59</u> , to <u>5/1</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 30</u> , 19 <u>59</u> , and that death occurred at <u>2:05 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>202 Dover St. Easton, Md.</u> DATE SIGNED <u>5-5-59</u>							
ACTUAL SIGNATURE <u>Robert W. Trever</u>				PHYSICIAN'S NAME (Type) <u>Robert W. Trever</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>				22b. DATE THEREOF <u>May 4, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Hilbert Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Federalburg, Md.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harvey Williams - Federalburg, Md.</u> ADDRESS <u>Federalburg, Md.</u>				24a. REC'D BY REGISTRAR <u>MAY 11 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

06008

Reg. Dist. No.

6020

1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Talbot</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pike River</i>		c. LENGTH OF STAY IN 1b <i>Life</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>1</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Samuel A. Prompton</i>		4. DATE OF DEATH Month Day Year <i>5-13-1959</i>	
5. SEX <i>M.</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 20, 1870</i>
9. AGE (In years last birthday) <i>89</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waterman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Cyber</i>	
11. BIRTHPLACE (State or foreign country) <i>Clifton Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Sincent Prompton</i>		14. MOTHER'S MAIDEN NAME <i>Wilmina Melvin</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No.</i>		16. SOCIAL SECURITY NO. <i>None.</i>	
17. INFORMANT <i>May Ednum Fighman Md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial heart failure</i> 722.0 DUE TO <i>chronic valvular heart disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <i>pleuruntant cystitis</i> (c) <i>12 years</i>		INTERVAL BETWEEN ONSET AND DEATH <i>10 years</i> <i>10 1/2 years</i> <i>12 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>May 12, 1959</i> to <i>May 13, 1959</i> that I last saw the deceased alive on <i>May 12, 1959</i> , and that death occurred at <i>6:15</i> M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED <i>May 13, 1959</i>	
ACTUAL SIGNATURE <i>Guy M Reeser</i> M.D.			
PHYSICIAN'S NAME (Type) <i>GUY M REESER Sr</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	22b. DATE THEREOF <i>May 15, 59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Pike River Md</i>	22d. LOCATION (City, town, or county) (State) <i>Talbot Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. R. Moore</i> ADDRESS <i>Pike River</i>		24a. REC'D BY REGISTRAR DATE <i>MAY 15 '59</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knox</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be returned for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6008 CERTIFICATE OF DEATH

Reg. Dist. No.

06007

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN <u>5 HRS. 20 mins</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GOLDSBORO, MD</u>		d. STREET ADDRESS <u>05X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MEMORIAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BABY</u> Middle <u>BOY</u> Last <u>FOUNTAIN</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>26</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 26, 1959</u>
9. AGE (In years last birthday) yrs. <u>5</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>20</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CLARENCE COLLISON</u>		14. MOTHER'S MAIDEN NAME <u>RUTH FOUNTAIN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>MOTHER - GOLDSBORO, MD.</u>	
17. INFORMANT <u>MOTHER - GOLDSBORO, MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracranial Hemorrhage</u> <u>760.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prematurity 1st 6th</u> DUE TO (c) <u>6 hrs</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-26</u> , 19 <u>59</u> , to <u>5-26</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5-26</u> , 19 <u>59</u> , and that death occurred at <u>11</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John S Baybutt</u> M.D. <u>205 Earle Ave Easton Md</u>		DATE SIGNED <u>6-4-59</u>	
PHYSICIAN'S NAME (Type) <u>JOHN E Baybutt</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Interred</u>		22b. DATE THEREOF <u>5/28/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Memorial Hospd Easton Md</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>—</u> ADDRESS		24a. REC'D BY REGISTRAR <u>—</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. King</u>	
DATE <u>JUN 8 '59</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
Items 18-21 Film 243 8-5-59 ans											
6021 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Reg. Dist. No. 06009											
1. PLACE OF DEATH a. COUNTY Talbot MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) near Trappe					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS 1307 Greenmount Avenue						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print)			First JOHN		Middle W		Last FRIEND		4. DATE OF DEATH		
							Month May		Day 12 Year 19 59		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 16, 1921		9. AGE (In years last birthday) 39 3/4		10. IF UNDER 1 YEAR IF UNDER 24 HRS.	
								Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Not Employed					10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Oklahoma		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard C. Friend					14. MOTHER'S MAIDEN NAME Edna Stanley						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 213-18-7694		17. INFORMANT Address Mrs Clinton Ruth Charlotte, N. C.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning, found drowned 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Found drowned						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 5/12/59					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Trappe Creek		20f. (City or town) nr. Trappe (County) Talbot (State) Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input checked="" type="checkbox"/> .											
ACTUAL SIGNATURE Paul F. Guerin					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED 5/15/59	
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.					ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>						
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 5/18/59		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.			22d. LOCATION (City, town, or county) Baltimore, Md. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook Inc., ADDRESS 1217 St. Paul St.,					24a. REC'D BY REGISTRAR DATE MAY 20 1959		24b. REGISTRAR'S SIGNATURE Arthur S. Hanes				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6009 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06010

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxford</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Clarence</u> Middle <u>Green</u> Last <u>Green</u>				4. DATE OF DEATH Month <u>5</u> Day <u>27</u> Year <u>1959</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-23-1903</u>		9. AGE (In years last birthday) <u>55</u> yrs.	IF UNDER 1 YEAR Months <u>5</u> Days <u>27</u>	IF UNDER 24 HRS. Hours <u>55</u> Min. <u>27</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Green</u>				14. MOTHER'S MAIDEN NAME <u>Leah Coleman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-12-544</u>		17. INFORMANT Address <u>Mary Etta Green, Oxford</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Immer</u> (a), stating the underlying cause lost. DUE TO (c) <u>Immer</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Immer</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>19</u> o. m. <u>19</u> p. m.	Month, Day, Year <u>5/30/59</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>talbot</u>		(County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Louis Meltz</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>WELTY</u>		DATE SIGNED <u>5-29-59</u>					
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/30/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Richards Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>talbot Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Dorland, Boston, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 8 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12
2002 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: John Doe

2. Date of Death: 10/15/2002

3. Place of Death: Home

4. Age: 65 Sex: M

5. Race: W

6. Cause of Death: Myocardial Infarction

7. Manner of Death: Natural

8. Signature of Medical Examiner: [Signature]

9. Date of Signature: 10/16/2002

10. Address of Medical Examiner: 123 Main St, Baltimore, MD 21201

11. Telephone: 410-555-1234

12. I hereby certify that the above is a true and correct statement of the facts as they appeared to me at the time of my examination.

13. I am a duly qualified Medical Examiner under the laws of the State of Maryland.

14. I am not a relative of the deceased.

15. I am not a partner, agent, or employee of the deceased.

16. I am not a partner, agent, or employee of the decedent's estate.

17. I am not a partner, agent, or employee of the decedent's business.

18. I am not a partner, agent, or employee of the decedent's firm.

19. I am not a partner, agent, or employee of the decedent's company.

20. I am not a partner, agent, or employee of the decedent's corporation.

21. I am not a partner, agent, or employee of the decedent's partnership.

22. I am not a partner, agent, or employee of the decedent's association.

23. I am not a partner, agent, or employee of the decedent's union.

24. I am not a partner, agent, or employee of the decedent's organization.

25. I am not a partner, agent, or employee of the decedent's institution.

26. I am not a partner, agent, or employee of the decedent's establishment.

27. I am not a partner, agent, or employee of the decedent's enterprise.

28. I am not a partner, agent, or employee of the decedent's concern.

29. I am not a partner, agent, or employee of the decedent's business.

30. I am not a partner, agent, or employee of the decedent's firm.

31. I am not a partner, agent, or employee of the decedent's company.

32. I am not a partner, agent, or employee of the decedent's corporation.

33. I am not a partner, agent, or employee of the decedent's partnership.

34. I am not a partner, agent, or employee of the decedent's association.

35. I am not a partner, agent, or employee of the decedent's union.

36. I am not a partner, agent, or employee of the decedent's organization.

37. I am not a partner, agent, or employee of the decedent's institution.

38. I am not a partner, agent, or employee of the decedent's establishment.

39. I am not a partner, agent, or employee of the decedent's enterprise.

40. I am not a partner, agent, or employee of the decedent's concern.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6010 CERTIFICATE OF DEATH

06011

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Salbot</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Ducon Anne's</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>2da. 12 hrs 5 min</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		d. STREET ADDRESS <i>Centerville 178-2</i>	
3. NAME OF DECEASED (Type or print) First <i>Charles</i> Middle <i>E</i> Last <i>Lloyd</i>		4. DATE OF DEATH Month <i>May</i> Day <i>10</i> Year <i>1959</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 7 1894</i>
9. AGE (In years last birthday) <i>64</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>farm tenant</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Edward Lloyd</i>		14. MOTHER'S MAIDEN NAME <i>Lucy Mason</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>217-14-8676</i>	
17. INFORMANT <i>Clara V Slaughter</i>		Address <i>Centerville Maryland</i>	
18. CAUSE OF DEATH [Enter only one cause per (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart failure</i> DUE TO <i>Aneurysm of ascending aorta</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>5:15</i> , 19 <i>59</i> , to <i>5:45</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>5/10/59</i> , and that death occurred at <i>5:45</i> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>E. C. H. Schmidt</i>		DATE SIGNED <i>219 S. Washington St. W. Md. 5/10/59</i>	
PHYSICIAN'S NAME (Type) <i>E. C. H. Schmidt</i>		<i>Easton 16, Maryland</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		22b. DATE THEREOF <i>May 13-59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Wardlaw Memorial</i>		22d. LOCATION (City, town, or county) (State) <i>Salbot Co Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>James B. Butler of Burton Bros, Centerville Md</i>		24a. REC'D BY REGISTRAR DATE <i>MAY 14 '59</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knease</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

FOR STATE
HEALTH DEPT.

Item 20b Film 2423-1-59

6011

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06012

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN TB <u>2 days 40 min</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		d. STREET ADDRESS <u>IVONE</u>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Henry</u> Last <u>Lord</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>9</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 6, 1921</u>
9. AGE (in years last birthday) <u>38</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Logging</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Alfred Lord</u>		14. MOTHER'S MAIDEN NAME <u>Annie Weaver</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WAR II</u>		16. SOCIAL SECURITY NO. <u>217-14-8752</u>	
17. INFORMANT <u>Elizabeth Lord Henderson, Md.</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Burned about 65% of his body 2 days +</u> <u>835X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Tractor turned over & caught on fire</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> <u>5-2-59</u> a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Farm</u>		20f. CITY OR TOWN <u>Caroline</u> (County) <u>RA</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>H.F. McHugh</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H.F. McHugh</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>5/9/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/11/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ridgely</u>		22d. LOCATION (City, town, or county) (State) <u>Ridgely Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.E. Boula's Greensboro, Md.</u>		24a. REC'D BY REGISTRAR <u> </u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

17

Continued

6017

FOR STATE
DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for patient information, medical history, and examination findings. The form is partially filled out with handwritten text.

1. PATIENT INFORMATION

2. MEDICAL HISTORY

3. EXAMINATION FINDINGS

4. CAUSE OF DEATH

5. SIGNATURES

6012 CERTIFICATE OF DEATH

Reg. Dist. No.

06013

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton				c. LENGTH OF STAY IN 1b 35 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 149 S. Washington St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOSEPH Middle VALENTINE Last MULLER				4. DATE OF DEATH Month May Day 12 Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 22, 1905	9. AGE (In years last birthday) 53 yrs.	IF UNDER 1 YEAR Months 53 Days 53 Hours 53 Min.	IF UNDER 24 HRS. Months 53 Days 53 Hours 53 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) electrician				10b. KIND OF BUSINESS OR INDUSTRY Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Joseph Muller				14. MOTHER'S MAIDEN NAME Nina M. Stevens			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 220-01-8675		17. INFORMANT Mrs. Valentine Muller Address Easton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Squamous Cell Carcinoma of Tongue DUE TO (b) 190.3 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Easton				20g. (County) Talbot		20h. (State) St. Michaels, Md.	
21. I certify that I attended the deceased from Sept 1, 1957 to 12 May, 1959 , that I last saw the deceased alive on 12 May, 1959 , and that death occurred at 10:00 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE R. Lane Wroth				DATE SIGNED 5-15-59			
PHYSICIAN'S NAME (Type) Dr. R. Lane Wroth				ADDRESS Talbot St. Michaels, Md.			
22a. BURIAL, CREMATION, REMQVAL (Specify) Burial		22b. DATE THEREOF May 15, 1959		22c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery		22d. LOCATION (City, town, or county) (State) Easton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Maurice W. Newnam & Son				ADDRESS Easton, Md.		24a. REC'D BY REGISTRAR DATE MAY 19 59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Krawa			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10013

CERTIFICATE OF DEATH

10013

<p>1. NAME OF DECEASED JOHN DOE</p>		<p>2. SEX Male</p>		<p>3. AGE 45</p>	
<p>4. DATE OF BIRTH 10/15/1925</p>		<p>5. PLACE OF BIRTH New York, N.Y.</p>		<p>6. RACE White</p>	
<p>7. OCCUPATION Teacher</p>		<p>8. MARITAL STATUS Married</p>		<p>9. DATE OF MARRIAGE 08/12/1948</p>	
<p>10. NAME OF SPOUSE Jane Doe</p>		<p>11. DATE OF DEATH 05/10/1970</p>		<p>12. PLACE OF DEATH New York, N.Y.</p>	
<p>13. CAUSE OF DEATH Heart Disease</p>		<p>14. MANNER OF DEATH Natural</p>		<p>15. SIGNATURE OF DECEASED (Blank)</p>	
<p>16. SIGNATURE OF WITNESS (Blank)</p>		<p>17. SIGNATURE OF PHYSICIAN (Blank)</p>		<p>18. SIGNATURE OF CLERK (Blank)</p>	
<p>19. NAME OF PHYSICIAN Dr. John Smith</p>		<p>20. NAME OF CLERK John Doe</p>		<p>21. NAME OF WITNESS Jane Doe</p>	
<p>22. NAME OF SPOUSE Jane Doe</p>		<p>23. NAME OF CHILDREN (Blank)</p>		<p>24. NAME OF OTHER RELATIVES (Blank)</p>	
<p>25. NAME OF DECEASED JOHN DOE</p>		<p>26. NAME OF DECEASED JOHN DOE</p>		<p>27. NAME OF DECEASED JOHN DOE</p>	
<p>28. NAME OF DECEASED JOHN DOE</p>		<p>29. NAME OF DECEASED JOHN DOE</p>		<p>30. NAME OF DECEASED JOHN DOE</p>	
<p>31. NAME OF DECEASED JOHN DOE</p>		<p>32. NAME OF DECEASED JOHN DOE</p>		<p>33. NAME OF DECEASED JOHN DOE</p>	
<p>34. NAME OF DECEASED JOHN DOE</p>		<p>35. NAME OF DECEASED JOHN DOE</p>		<p>36. NAME OF DECEASED JOHN DOE</p>	
<p>37. NAME OF DECEASED JOHN DOE</p>		<p>38. NAME OF DECEASED JOHN DOE</p>		<p>39. NAME OF DECEASED JOHN DOE</p>	
<p>40. NAME OF DECEASED JOHN DOE</p>		<p>41. NAME OF DECEASED JOHN DOE</p>		<p>42. NAME OF DECEASED JOHN DOE</p>	
<p>43. NAME OF DECEASED JOHN DOE</p>		<p>44. NAME OF DECEASED JOHN DOE</p>		<p>45. NAME OF DECEASED JOHN DOE</p>	
<p>46. NAME OF DECEASED JOHN DOE</p>		<p>47. NAME OF DECEASED JOHN DOE</p>		<p>48. NAME OF DECEASED JOHN DOE</p>	
<p>49. NAME OF DECEASED JOHN DOE</p>		<p>50. NAME OF DECEASED JOHN DOE</p>		<p>51. NAME OF DECEASED JOHN DOE</p>	
<p>52. NAME OF DECEASED JOHN DOE</p>		<p>53. NAME OF DECEASED JOHN DOE</p>		<p>54. NAME OF DECEASED JOHN DOE</p>	
<p>55. NAME OF DECEASED JOHN DOE</p>		<p>56. NAME OF DECEASED JOHN DOE</p>		<p>57. NAME OF DECEASED JOHN DOE</p>	
<p>58. NAME OF DECEASED JOHN DOE</p>		<p>59. NAME OF DECEASED JOHN DOE</p>		<p>60. NAME OF DECEASED JOHN DOE</p>	
<p>61. NAME OF DECEASED JOHN DOE</p>		<p>62. NAME OF DECEASED JOHN DOE</p>		<p>63. NAME OF DECEASED JOHN DOE</p>	
<p>64. NAME OF DECEASED JOHN DOE</p>		<p>65. NAME OF DECEASED JOHN DOE</p>		<p>66. NAME OF DECEASED JOHN DOE</p>	
<p>67. NAME OF DECEASED JOHN DOE</p>		<p>68. NAME OF DECEASED JOHN DOE</p>		<p>69. NAME OF DECEASED JOHN DOE</p>	
<p>70. NAME OF DECEASED JOHN DOE</p>		<p>71. NAME OF DECEASED JOHN DOE</p>		<p>72. NAME OF DECEASED JOHN DOE</p>	
<p>73. NAME OF DECEASED JOHN DOE</p>		<p>74. NAME OF DECEASED JOHN DOE</p>		<p>75. NAME OF DECEASED JOHN DOE</p>	
<p>76. NAME OF DECEASED JOHN DOE</p>		<p>77. NAME OF DECEASED JOHN DOE</p>		<p>78. NAME OF DECEASED JOHN DOE</p>	
<p>79. NAME OF DECEASED JOHN DOE</p>		<p>80. NAME OF DECEASED JOHN DOE</p>		<p>81. NAME OF DECEASED JOHN DOE</p>	
<p>82. NAME OF DECEASED JOHN DOE</p>		<p>83. NAME OF DECEASED JOHN DOE</p>		<p>84. NAME OF DECEASED JOHN DOE</p>	
<p>85. NAME OF DECEASED JOHN DOE</p>		<p>86. NAME OF DECEASED JOHN DOE</p>		<p>87. NAME OF DECEASED JOHN DOE</p>	
<p>88. NAME OF DECEASED JOHN DOE</p>		<p>89. NAME OF DECEASED JOHN DOE</p>		<p>90. NAME OF DECEASED JOHN DOE</p>	
<p>91. NAME OF DECEASED JOHN DOE</p>		<p>92. NAME OF DECEASED JOHN DOE</p>		<p>93. NAME OF DECEASED JOHN DOE</p>	
<p>94. NAME OF DECEASED JOHN DOE</p>		<p>95. NAME OF DECEASED JOHN DOE</p>		<p>96. NAME OF DECEASED JOHN DOE</p>	
<p>97. NAME OF DECEASED JOHN DOE</p>		<p>98. NAME OF DECEASED JOHN DOE</p>		<p>99. NAME OF DECEASED JOHN DOE</p>	
<p>100. NAME OF DECEASED JOHN DOE</p>		<p>101. NAME OF DECEASED JOHN DOE</p>		<p>102. NAME OF DECEASED JOHN DOE</p>	

10013

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, it should be filed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6013 CERTIFICATE OF DEATH

Reg. Dist. No.

06014

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>Dover Road</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Price</u> Middle <u>Mullikin</u> Last <u>Mullikin</u>		4. DATE OF DEATH Month <u>May</u> Day <u>19</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 25, 1914</u>
9. AGE (In years lost birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Clarence Mullikin</u>		14. MOTHER'S MAIDEN NAME <u>Marqoret Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-347586</u>	
17. INFORMANT <u>Mrs. J. Price Mullikin, Easton, Md. R.N.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>492x Acute Hemorrhagic Pneumonia</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-30</u> , 19 <u>59</u> , to <u>5-19</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5-19</u> , 19 <u>59</u> , and that death occurred at <u>2:15 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William L. Winters</u>		ADDRESS (Street, city or town, state) <u>2105 DOVER EASTON MD</u>	
DATE SIGNED <u>5/20/59</u>			
PHYSICIAN'S NAME (Type) <u>WILLIAM L. WINTERS</u>		<u>EASTON MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>May 22, 59</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Easton Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Easton Md</u>	
24a. REC'D BY REGISTRAR <u>[Signature]</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
DATE <u>MAY 22 '59</u>			

10011

MARYLAND STATE DEPT. OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

Form 100-100

PLACE OF DEATH		MARRIAGE	
1. Name of deceased		2. Date of death	
3. Age at death		4. Sex	
5. Race		6. Color	
7. Birth date		8. Birth place	
9. Date of death		10. Time of death	
11. Cause of death		12. Manner of death	
13. Signature of physician		14. Signature of registrar	
15. Date of registration		16. Place of registration	
17. Name of registrar		18. Signature of registrar	
19. Date of registration		20. Place of registration	
21. Name of registrar		22. Signature of registrar	
23. Date of registration		24. Place of registration	
25. Name of registrar		26. Signature of registrar	
27. Date of registration		28. Place of registration	
29. Name of registrar		30. Signature of registrar	
31. Date of registration		32. Place of registration	
33. Name of registrar		34. Signature of registrar	
35. Date of registration		36. Place of registration	
37. Name of registrar		38. Signature of registrar	
39. Date of registration		40. Place of registration	
41. Name of registrar		42. Signature of registrar	
43. Date of registration		44. Place of registration	
45. Name of registrar		46. Signature of registrar	
47. Date of registration		48. Place of registration	
49. Name of registrar		50. Signature of registrar	
51. Date of registration		52. Place of registration	
53. Name of registrar		54. Signature of registrar	
55. Date of registration		56. Place of registration	
57. Name of registrar		58. Signature of registrar	
59. Date of registration		60. Place of registration	
61. Name of registrar		62. Signature of registrar	
63. Date of registration		64. Place of registration	
65. Name of registrar		66. Signature of registrar	
67. Date of registration		68. Place of registration	
69. Name of registrar		70. Signature of registrar	
71. Date of registration		72. Place of registration	
73. Name of registrar		74. Signature of registrar	
75. Date of registration		76. Place of registration	
77. Name of registrar		78. Signature of registrar	
79. Date of registration		80. Place of registration	
81. Name of registrar		82. Signature of registrar	
83. Date of registration		84. Place of registration	
85. Name of registrar		86. Signature of registrar	
87. Date of registration		88. Place of registration	
89. Name of registrar		90. Signature of registrar	
91. Date of registration		92. Place of registration	
93. Name of registrar		94. Signature of registrar	
95. Date of registration		96. Place of registration	
97. Name of registrar		98. Signature of registrar	
99. Date of registration		100. Place of registration	

Date

MAY 1964

100-100-100

100-100-100

100-100-100

100-100-100

6014 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ <u>Federalburg</u> 05X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTON Memorial Hosp.</u>		d. STREET ADDRESS <u>Rt. 2 - Box 249</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MR William Carlton Neal</u>		4. DATE OF DEATH Month Day Year <u>May 6 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 24 1890</u>
9. AGE (In years lost birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Charles Miner & Son</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Andrew Neal</u>		14. MOTHER'S MAIDEN NAME <u>Mary Gayline Carper</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>232-12-6019</u>	
17. INFORMANT <u>MRS. Letha Neal, wife - same</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thoracic epidural abscess</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Lobular pneumonia</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.	20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u>		DATE SIGNED <u>24 May 59</u>	
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>		ADDRESS (Street, city or town, state) <u>219 S. Washington St. Federalburg Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 10, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Roselawn Memorial Gardens</u>	22d. LOCATION (City, town, or county) (State) <u>Bluefield, West Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. P. Hampton Son, Federalburg Md.</u>		24a. REC'D BY REGISTRAR <u>MAY 11 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be obtained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

11-10-10

<p>1. NAME OF DECEASED JOHN B. TAYLOR</p>		<p>2. SEX MALE</p>		<p>3. AGE 45</p>	
<p>4. DATE OF DEATH 11-10-10</p>		<p>5. TIME OF DEATH 10:00 AM</p>		<p>6. PLACE OF DEATH HOME</p>	
<p>7. OCCUPATION CLERK</p>		<p>8. MARITAL STATUS MARRIED</p>		<p>9. PLACE OF BIRTH MD</p>	
<p>10. CAUSE OF DEATH HEART DISEASE</p>		<p>11. MANNER OF DEATH NATURAL</p>		<p>12. SIGNATURE OF PHYSICIAN [Signature]</p>	
<p>13. SIGNATURE OF WITNESS [Signature]</p>		<p>14. SIGNATURE OF DECEASED [Signature]</p>		<p>15. SIGNATURE OF REGISTRAR [Signature]</p>	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH RECORDS ACT, AND IS NOT VALID FOR ANY OTHER PURPOSES.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9, Film G242 5-8-59 md

CERTIFICATE OF DEATH

Reg. Dist. No.

06016

6015

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Penn. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>3 hrs 40 min</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centerville</u>		d. STREET ADDRESS <u>178-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Edmund</u> Last <u>Nelson</u>		4. DATE OF DEATH Month <u>May</u> Day <u>1</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 21, 1897</u>
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Motor Equip. op.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State Roads Comm'n</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>W. H. Nelson</u>		14. MOTHER'S MAIDEN NAME <u>Frances Thomas</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-16-8331</u>	
17. INFORMANT <u>Bertha P. Nelson</u>		Address <u>Centerville Md</u>	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> <u>4.20.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>recent and old.</u> (c) <u>Coronary occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>4:10 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>EC. H. Schmidt</u>		DATE SIGNED <u>May 5, 1959</u>	
PHYSICIAN'S NAME (Type) <u>EC. H. Schmidt</u>		ADDRESS (Street, city or town, state) <u>219 S. Washington St. Easton, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 4-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Chestnutfield</u>		22d. LOCATION (City, town, or county) (State) <u>Centerville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James W. Banta</u>		ADDRESS <u>Banta Bw. Centerville, Md.</u>	
24a. REC'D BY REGISTRAR <u>May 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6022

CERTIFICATE OF DEATH

Reg. Dist. No.

06017

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Royal Oak		c. LENGTH OF STAY IN 1b 11 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Royal Oak	
3. NAME OF DECEASED (Type or print) First Middle Last FRANCIS M. O'BRIEN		4. DATE OF DEATH Month Day Year May 27, 19 59	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 12, 1876
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) policeman		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Michael O'Brien		14. MOTHER'S MAIDEN NAME Mary E. McCarthy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 126-14-0530	
17. INFORMANT Mrs. Josephine O'Brien		Address Royal Oak, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction - immediate 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) atherosclerosis coronary Ar. Id. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) chronic cardiac failure. Diabetes Mellitus			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-21 , 19 54 to 5-27 , 19 59 that I last saw the deceased alive on 5-27 , 19 59 , and that death occurred at 2:30 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) St. Michaels, Md. DATE SIGNED 5-25-59 ACTUAL SIGNATURE Dr. Guy M. Reeser, Jr. M.D. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REINTERMENT (Specify) Burial		22b. DATE THEREOF May 30, 1959	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn Memorial		22d. LOCATION (City, town, or county) (State) near Easton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son		ADDRESS Easton, Maryland	
24a. REC'D BY REGISTRAR DATE JUN 2 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 06018									
1. PLACE OF DEATH a. COUNTY <u>TALBOT</u>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN 1b <u>8 days</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>CAROLINE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Easton Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <u>Rt #2 - Box 73-C</u>		3. NAME OF DECEASED (Type or print) <u>CLAYTON GREGORY</u>		4. DATE OF DEATH Month <u>May</u> Day <u>5</u> Year <u>1959</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 11, 1950</u>		9. AGE (in years last birthday) <u>8</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PUBLIC SCHOOL STUDENT</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Clayton D. Rosser</u>		14. MOTHER'S MAIDEN NAME <u>Linda Patchett</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT (Address) <u>Linda P. Rosser (mother) - Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Fractures - Severe Head Injury</u> 813X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Internal Injuries</u> DUE TO (c) <u>8 days</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>While Motor vehicle with bicycle</u>							
20c. TIME OF INJURY Hour <u>4</u> a. m. <u>4-27</u> p. m. <u>1959</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway - Federalsburg</u>		20f. (City or town) <u>Federalsburg</u>		20g. (County) <u>Caroline</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Dawson O. George</u>		EXAMINER'S NAME (Type) <u>Dawson O. George, M.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 8, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hill Crest Cemetery</u>		22d. LOCATION (City, town, or county) <u>Federalsburg, Maryland</u>		22e. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.J. Frampton and Son, Federalsburg, Maryland</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>MAY 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

80118

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND
COUNTY OF BALTIMORE
I, the undersigned, being a duly qualified Medical Examiner, do hereby certify that on the 11th day of May, 1960, at the residence of the deceased, I examined the body of
JAMES EARL RAY, JR.
who died at the residence of the deceased, and found that the cause of death was
Homicide
and that the manner of death was
Suicide
and that the death was caused by
a gunshot wound of the chest.
I further certify that the deceased was not suffering from any communicable disease, and that the death was not caused by any of the diseases listed in the Maryland Health Code, and that the death was not caused by any of the diseases listed in the Maryland Health Code, and that the death was not caused by any of the diseases listed in the Maryland Health Code.

NAME OF DECEASED		JAMES EARL RAY, JR.	
DATE OF DEATH		MAY 11, 1960	
PLACE OF DEATH		RESIDENCE OF DECEASED	
AGE		34	
SEX		MALE	
RACE		WHITE	
OCCUPATION		None	
EDUCATION		None	
MARRIAGE		None	
RELIGION		None	
CAUSE OF DEATH		Homicide	
MANNER OF DEATH		Suicide	
DETAILS OF DEATH		a gunshot wound of the chest	
SIGNATURE OF EXAMINER		[Signature]	
TITLE OF EXAMINER		Medical Examiner	
DATE OF EXAMINATION		MAY 11, 1960	
PLACE OF EXAMINATION		RESIDENCE OF DECEASED	
FINGERPRINTS		[Fingerprints]	
X-RAYS		[X-Rays]	
LABORATORY TESTS		[Laboratory Tests]	
OTHER TESTS		[Other Tests]	
REMARKS		[Remarks]	

FOR STATE
HEALTH DEPT.

THIS CERTIFICATE IS VALID FOR THE PURPOSE OF OBTAINING A DEATH CERTIFICATE ONLY. IT IS NOT VALID FOR ANY OTHER PURPOSE.

6017

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN Jb <u>5 hrs 25 mins</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MEMORIAL</u>		1 d. STREET ADDRESS <u>CORDOVA</u>	
3. NAME OF DECEASED (Type or print) <u>MR. WILLIAM JAMES Sedgwick</u>		4. DATE OF DEATH <u>MAY 15 1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 12, 1894</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR <u>3</u> Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>MR. WILLIAM JAMES Sedgwick</u>		14. MOTHER'S MAIDEN NAME <u>GERTRUDE FERGUSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>World War I</u>		16. SOCIAL SECURITY NO. <u>217-30-7649</u>	
17. INFORMANT <u>Mrs. Susie Sedgwick, Cordova, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-14</u> , 1959, to <u>5-15</u> , 1959, that I last saw the deceased alive on <u>5-15</u> , 1959, and that death occurred at <u>2:15 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert W. Trever</u>		ADDRESS (Street, city or town, state) <u>202 DOVER ST. EASTON MD.</u>	
PHYSICIAN'S NAME (Type) <u>Robert W. TREVER</u>		DATE SIGNED <u>5-15-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 18, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Easton Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John D. Williams</u>		24a. REC'D BY REGISTRAR <u>Arthur E. Kline</u>	
ADDRESS <u>Easton, Md.</u>		DATE <u>MAY 18 '59</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26